VISION PROGRAM MANUAL

Kentucky Medicaid Program
Vision Services Benefits
Policies and Procedures

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

KENTUCKY MEDICAID PROGRAM

VISION PROGRAM MANUAL

POLICIES AND PROCEDURES

Cabinet for Health Services
Department for Medicaid Services
Division of Physical Health
Frankfort, KY 40621

TRANSMITTAL #20
06/01

INTRODUCTION

SECTION I

TABLE OF CONTENTS

TABLE OF CONTENTS

SECTION I - INTRODUCTION

A. Introduction

The Kentucky Medicaid Vision Program Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual contains basic information concerning coverage and policy. Precise adherence to policy shall be imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

KENTUCKY MEDICAID PROGRAM

SECTION II

SECTION II - KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients. The Medicaid Program shall be the payor of last resort. If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable charge.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policy are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provider Medicaid services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, recipients may select the provider from whom they wish to receive their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same services shall not be tendered to the

recipient, and a payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

The provider's adherence to the application of policies in this manual shall be monitored through either post-payment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to post-payment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Providers of medical service or authorized representative attest by their signatures (not facsimiles) on the claim form submitted, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment, or both. Stamped or computer generated signatures shall be not acceptable.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

B. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulation define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45(d) (5) as follows, "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing **RECEIPT** by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. **ONLY** twelve (12) months shall elapse between **EACH RESUBMISSION** of the claim by the Program.

C. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary physician or family doctor. The primary physician shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services. KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

Optometry and ophthalmology services shall not be affected by KenPAC. You should continue to bill as usual for any covered services provided to patients with a "green" MAID card.

SECTION II - KENTUCKY MEDICAID PROGRAM

D. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, provider and recipients shall comply with the provision set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients assigned to the lock-in program shall have a pink MAID card and the name of the case manager shall appear on the face of the card.

CONDITIONS OF PARTICIPATION

SECTION III

SECTION III - CONDITIONS OF PARTICIPATION

A. General Information

For purposes of participation in the Kentucky Medicaid Program, a Medicaid provider number shall be assigned to each provider. Optometry provider numbers have a prefix of "77". Optician provider numbers have a prefix of "52". Failure to report the correct provider number on the claim submitted for services provided may result in incorrect or nonpayment of claims. If a provider is terminated or suspended from Kentucky Medicaid participation, services provided to Kentucky Medicaid recipients after the effective date of termination or suspension shall not be payable.

B. Licensure

All optometrists shall be certified by the Kentucky Board of Optometric Examiners or in the state in which they practice and be required to submit proof of licensure. Annual proof of licensure renewal (which includes effective date and expiration date) shall be required and submitted to the Kentucky Medicaid Program, Individual Provider Services Branch for providers who desire to remain actively enrolled.

All opticians shall hold a current license in the Commonwealth of Kentucky as ophthalmic dispensers and conduct business in accordance with KRS Chapter 326. Out-of-Kentucky opticians shall be required to submit proof of licensure and license renewal as dictated by their respective state boards. Annual proof of licensure renewal (which includes effective date and expiration date) shall be required and submitted to the Kentucky Medicaid Program, Provider Enrollment Section for providers who desire to remain actively enrolled.

NOTE: Non-submission of proof of current licensure shall result in loss of eligibility of the provider **and** denial of claims submitted for payment.

SECTION III - CONDITIONS OF PARTICIPATION

C. Clinics and Professional Service Corporations (P.S.C.)

Kentucky Medicaid shall permit a group of optometrists and ophthalmic dispensers to enroll in the Program as a clinic or a Professional Service Corporation (P.S.C.) under certain conditions. A **clinic** shall be defined by Kentucky Medicaid as a group of several providers who practice cooperatively and collaboratively, and who perform a majority of their services in the primary care setting.

Optometrists and ophthalmic dispensers who are employed and salaried by a clinic or professional service corporation may request that payment for their individual services provided to eligible Kentucky Medicaid Program recipients be made directly to the clinic or professional service corporation. Each optometrist and ophthalmic dispenser employed in these settings shall be required to sign and submit a Statement of Authorization Form, (MAP-347).

A **Professional Service Corporation** shall be defined by Kentucky Medicaid as it is defined specifically according to Commonwealth of Kentucky Revised Statutes, Chapter 274 (KRS 274.990). Out-of-state Professional Service Corporations shall be defined by their individual state law.

D. Freedom of Choice Concept

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid recipients and to bill the program for the medical care provided.

SECTION III - CONDITIONS OF PARTICIPATION

E. Medical Records

Medical records shall substantiate the services billed by the optometrist. The medical records shall reflect the nature and extent of counseling and coordination of care and be supportive of medical necessity. Optometrist notes shall be contained in these medical records. These notes shall be entered personally by the optometrist or typewritten if signed by the optometrist. **ALL** records shall be signed, dated, and include the following:

Recipient's identifying data
Complete vision analysis and therapy records
Prescriptions
Visual field charts
Orthoptic evaluation records
Orthoptic records
Tonograms
Fitting measurements, identifying lens and frame specifications
Any other documentation which supports the medical necessity of the services performed

In the office or other outpatient setting, counseling and coordination of care shall be provided in the presence of the recipient (patient) if the time spent providing those services is used to determine the level of care (service) reported. The duration of counseling or coordination of care that is provided face-to-face may be estimated; however, that estimate, along with the total duration of the visit, shall be recorded when time is used for the selection of visit that involves predominately coordination of care and counseling.

Medical records shall substantiate the services billed by the ophthalmic dispenser. The medical records shall reflect the nature and extent of counseling and coordination of care and be supportive of medical necessity. Optician notes (if any) shall be contained in these medical records. These notes may be entered personally by the optician or may be typewritten if signed by the optician. **All** records shall be signed, dated, and include the following:

Recipient's identifying data
Prescriptions
Fitting measurements, identifying lens and frame specifications

Medical records of Kentucky Medicaid Program recipients shall be maintained by the provider for a minimum of five (5) years or for any additional time as necessary in the event of an audit exception or other dispute. These records, and any other information regarding Medicaid Program paid claims shall be maintained in an organized central file, provided to the Department upon request, and made available for inspection and photocopy by Department personnel or its representative.

F. Medicaid Participation Overview

Any optometrist and ophthalmic dispenser **licensed** by their respective state may participate in the Kentucky Medicaid Program by enrolling in the Program and requesting payment for covered services provided to eligible program recipients. A copy of this licensure or any renewal of licensure shall be submitted by the provider and maintained on file in Kentucky Medicaid. The provider shall complete the Provider Agreement (MAP-343) and the Provider Information Form (MAP-344). All participating providers shall comply with the requirements specified in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673. One (1) copy of each completed form shall be returned to the Department, whereupon a provider number shall be assigned to the provider. The number serves to identify statements submitted to the Program, and shall be utilized in the preparation of all payment records.

Optometrists and ophthalmic dispensers who choose to enroll in the Kentucky Medicaid Program as a clinic or a Professional Service Corporation (PSC) shall complete the MAP-343 and Map-344 forms as referenced above, and sign and submit a Statement of Authorization Form (MAP-347). Return these forms to the Department, whereupon a provider number shall be assigned to the clinic or PSC.

If a provider enrolls in Kentucky Medicaid and chooses to submit claims electronically, the provider shall complete and submit a Provider Agreement

Addendum (MAP-380). If a third party computer billing agency is used to prepare the media for the provider, the electronic media billing agency shall also complete and submit an agreement (MAP-246). One (1) copy of each completed form shall be returned to the Department for Medicaid Services.

Optometry providers located outside the United States and its territories shall not be granted enrollment in the Kentucky Medicaid Program.

Notification in writing shall be made to the Medicaid Program regarding any change in Program participation status (e.g., change of ownership, address change, closing).

G. Overview of Required Procedures

The Medicaid Program shall use several investigative and screening methods to detect any abuse on the part of the provider or recipient. Computer print-outs shall be reviewed periodically (e.g., quarterly). Data shall be compared against norms of the specific medical service areas for number of medical services per recipient, cost per service and cost per recipient. If the figures show significant deviations from the norms, the provider shall be identified as needing an in-depth review. Records shall be more thoroughly examined and provider and recipient contact shall be initiated to determine the cause for the unusual pattern or care.

PROGRAM COVERAGE

SECTION IV

IV. PROGRAM COVERAGE

A. Eligibility Guidelines

Medical Assistance Identification (MAID) cards shall be issued to all recipients eligible for program benefits. The ten (10) digit MAID number which appears on the identification card shall be entered in Field 9a on the HCFA-1500 claim form submitted for payment. It is recommended that the provider or providers staff correctly identify the recipient whose name appears on the card at the time of service delivery and carefully note the period of eligibility to validate that the recipient is eligible for benefits on the date of service. A second form of recipient identification may be requested by the provider in order to verify the identity of the recipient. Kentucky Medicaid **shall not** reimburse for services provided to ineligible recipients.

B. Examination, Diagnostic and Treatment Services

The HCFA-1500 claim form (revised 12/90) shall be used to report vision services provided to eligible Medicaid recipients. This specific form shall be submitted completely, accurately, and legibly to the Kentucky Medicaid fiscal agent within twelve (12) months from the date of service or within six (6) months of the Medicare or other insurance adjudication date. Specific guidelines for completion of the HCFA-1500 shall be available through the fiscal agent. Actual signatures of the provider or authorized others shall be required on claims submitted for payment.

The Kentucky Medicaid Program shall provide reimbursement to optometrists for vision examinations and limited diagnostic and treatment services provided for eligible Kentucky Medicaid recipients of **all ages** according to the Physicians' Current Procedural Terminology/Health Care Financing Administration Common Procedural Coding System (CPT codes) reported on claims and ONLY as the descriptors of the codes allow. Kentucky Medicaid shall announce occasions when code descriptors are not recognized or are altered for Kentucky Medicaid reimbursement purposes. If protocols in the CPT are more stringent than limits stated in this Section, the protocols in the CPT will take precedence.

SECTION IV - PROGRAM COVERAGE

Kentucky Medicaid shall not provide separate payment for procedure that are part of a more comprehensive service; therefore, two (2) or more procedure codes shall not be reported or reimbursed separately if one (1) code is available to appropriately identify the comprehensive service provided.

1. Covered Services

Following is a list of procedure codes corresponding to covered optometry vision examination, diagnostic and treatment services by Kentucky Medicaid. These codes listed in numerical order are more specifically identified in the AMA Physicians' Current Procedural Terminology (CPT) book.

65205	81000	87081	92120	92499	99211	99255
65210	82947	87082	92130	92531	99212	99301
65220	82948	87083	92140	92532	99213	99302
65222	82951	87084	92225	92533	99214	99303
65430	82952	87085	92226	92534	99215	99311
65435	85002	87205	92230	95930	99221	99312
67820	85007	90901	92235	95999	99222	99313
68761	85009	92002	92250	96111	99223	99321
68801	85014	92004	92260	96115	99231	99322
68810	85018	92012	92265	97110	99232	99323
76511	85021	92014	92270	97112	99233	99331
76512	85022	92015	92275	97139	99241	99332
76516	85023	92020	92283	97530	99242	99333
76529	85024	92060	92284	99050	99243	99341
76999	85025	92065	92285	99178	99244	99342
80002	85031	92070*	92286	99201	99245	99343
80003	85041	92081	92310	99202	99251	99351
80004	85048	92082	92311	99203	99252	99352
80005	86490	92083	92312	99204	99253	99353
80006	86510	92100	92313	99205	99254	

NOTE: Optometry claims submitted for the above referenced covered CPT procedures shall reflect the usual and customary billed charge to the general public. These procedures are covered for recipients of all ages.

*Procedure code 92070 shall be used to bill the therapeutic bandage lens used in the treatment of diseases, (e.g., bullous keratopathy or non-healing corneal ulcers).

Contact lenses are non-covered and shall not be substituted as eyeglasses.

2. Limitations on Covered Examination, Diagnostic and Treatment Services

Effective 12-01-93, **new** patient Evaluation and Management office or other outpatient services codes 99201, 99202, 99203, 99204 and 99205 shall be limited to one (1) per recipient, per provider, per three (3) year period.

Established patient Evaluation and Management office or other outpatient services codes 99214 and 99215 shall be limited to one (1) per recipient, per provider, per twelve (12) month period.

Effective 12-01-93, **new** patient Evaluation and Management home services codes 99321, 99322, 99323, 99342, 99342, and 99343 shall be limited to one (1) per recipient, per provider, per three (3) year period. Established Evaluation and Management home service code 99353 shall be limited to one (1) per recipient, per provider, per twelve (12) month period.

Effective 12-01-93, **new** patient ophthalmological procedure codes 92002 and 92004 shall be limited to one (1) per recipient, per provider, per three (3) year period.

Established patient ophthalmological procedure codes 92012 and 92014 shall be limited to one (1) per recipient, per provider, per twelve (12) month period.

Procedure codes 92002, 92004, 92012, and 92014 shall NOT be reported and billed with the following procedure codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215.

Procedure codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215 shall not be reported and billed with the

following procedure codes: 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, and 99255.

Evaluation and management service code 99211 shall not be payable unless there is actual physician-patient contact during the visit.

Application of these policies shall be subject to enforcement by both computer audits and edits and the postpayment review of claims.

3. Limitations on Covered Visual Fields and Ophthalmoscopy Services

Visual field examinations (procedure codes 92081, 92082, and 92083) shall be limited to one (1) examination per recipient, per provider, per date of service. These procedure codes shall not be billed together on the same date of service.

Ophthalmoscopy examination procedure codes (92230, 92235, 92250 and 92260) shall be limited to one (1) examination per recipient, per provider, per date of service. These procedure codes shall not be billed together.

4. Limitations on Covered Laboratory Services

The Clinical Laboratory Improvement Amendments (CLIA) requirements became effective September 1, 1992. For Kentucky Medicaid to provide reimbursement for laboratory services after this date, **all** providers who perform **any** laboratory test shall apply for and be issued CLIA certification, and possess a CLIA identification number this includes commonly performed tests (e.g., rapid strep, nasal smears, etc.) with CPT procedure codes 80002-89399.

Each CLIA identification number submitted to Kentucky Medicaid is entered into the corresponding provider record and cross-referenced with the provider number in the computer system. Effective December 1, 1992, any provider billing laboratory codes without an appropriate CLIA number on file, shall have any uncertified laboratory code payments reclaimed by Kentucky Medicaid. Monitoring for CLIA numbers was initiated on January 1, 1993.

Providers who perform any laboratory tests may request information or apply for CLIA certification at the following address:

ATTN CLIA LABORATORY INQUIRY
HEALTH CARE FINANCING ADMINISTRATION
PO BOX 26689
BALTIMORE MD 21207-0489

Upon receipt of CLIA certification and issuance of a CLIA number, individual optometrists providing laboratory services shall provide a copy of the CLIA certification of approval and the CLIA number to Department for Medicaid Services; Individual Provider Services Branch; 275 East Main; Frankfort, KY 40621. The individual optometrist shall report his Kentucky Medicaid eight (8) digit provider number at the same time to facilitate cross-referencing.

All optometrists enrolled in Kentucky Medicaid who are CLIA certified and have registered their CLIA certification numbers with Kentucky Medicaid Provider Enrollment may bill and receive reimbursement for the following laboratory procedures performed for Kentucky Medicaid recipients:

A complete blood count (CBC) shall be billed when three (3) or more of the following tests are performed: 85007 or 85009, 85014, 85018, 85041, or 85048. When a CBC is performed and billed to Kentucky Medicaid separate payment for any one (1) of these components shall not be allowed.

Reimbursement for both culture and smear for bacteria shall not be allowed by Kentucky Medicaid for the same diagnosis of a recipient, on the same date of service by the same provider.

Application of policy related to laboratory services shall be subject to enforcement by computer audits, edits and the postpayment review of claims.

SECTION IV – PROGRAM COVERAGE

C. Eyeglasses

1. Conditions of coverage

The following criteria shall be met for Kentucky Medicaid Program coverage of eyeglasses.

(a) Recipient's Age

The laboratory costs of **eyeglasses** or eyeglass parts and the appropriate dispensing fee for services provided for eligible Kentucky Medicaid Program recipients under twenty-one (21) years of age shall be payable by the Kentucky Medicaid Program.

(b) Diagnosis

Eligible recipients shall have a diagnosed visual condition that requires eyeglasses and is included in one (1) of the following four (4) categories:

(1) Amblyopia
(2) Post surgical eye condition
(3) Diminished or subnormal vision
(4) Other diagnosis which indicates need for eyeglasses

(c) Minimum Prescription

Visual conditions requiring prescriptions for correction shall contain power in the stronger lens no weaker than the following:

+0.50 or 0.50 sphere +0.50 or 0.50 cylinder
0.50 diopter of vertical prism
A total of 2 diopter of lateral prism

(d) Frame and Lenses Requirement

(1.) Frame

- All frames shall be first quality and free of defects. The material from which the frame is constructed shall be normally resistant to damage or breakage, and shall be finished with a high polish if indicated.

- To enable replacement of lenses and frame parts, all frames shall have imprinted on them the following information: Eye size, bridge size, temple length, and the manufacturer's name or trademark.

- The provider shall allow the recipient to try on and select from an adequate selection of appropriate, approved frame styles. The selection shall include a minimum of three (3) girl's and three (3) boy's frame styles, with three (3) sizes available in each style. The recipient shall be permitted to use his own frame, if he chooses. If the recipient selects frames non-approved by the Medicaid Program, the recipient shall be responsible for the payment of the frames. The Medicaid Program shall not pay the

difference in costs for designer frames or non-approved frames.

(2.) Lenses

- Only first quality lens shall be used. The lens shall be available in a complete range of corrected curves. The lens shall be free of defects, packaged in the manufacturer's original envelope or box, and meet the requirements of inspection, tolerance, and testing procedures as outlined in the American Standard Prescription Requirements.

- All lenses shall meet the current Food and Drug Administration (FDA) standards of impact resistance.

- If a change in prescription has been made within twelve (12) consecutive months of the initial prescription, only the new lenses shall be covered for change by Kentucky Medicaid. The new prescription shall meet the minimum change in prescription stated under limitations in coverage. The cost of a new frame shall not be covered by Kentucky Medicaid if the previously dispensed frame is intact and appropriate.

NOTE: Supplies and materials other than eyeglasses and visual aids used in a diagnostic service (e.g., eye drops, cotton swabs, etc.) shall be considered to be part of the service provided; therefore, Program payment for the service shall be all inclusive of costs of these items. Separate charges for these items shall not be allowed by Kentucky Medicaid and the recipient shall not be billed for these items.

D. Eyeglasses Coverage Limitations

1. Recipients under the age of twenty-one (21) shall be limited through the Vision Program to two (2) pairs of glasses per twelve (12) months in accordance with the following:

The recipient may have two (2) complete pairs of eyeglasses within a twelve (12) month period beginning with the date of the first or initial pair. Each recipient shall be limited to one (1) initial pair per twelve (12) months. The second or replacement pair may be totally new;

or

The recipient may receive any combination of parts for eyeglasses, two (2) fronts, one (1) temple, four (4) lenses; however, the total parts combined, provided and received shall not exceed the total parts contained in two (2) complete pairs of glasses;

or

The recipient may receive one (1) initial pair of eyeglasses or one (1) replacement pair and any combination of eyeglass parts so that the total parts combined do not exceed the total number of parts contained in an additional pair of glasses.

Additional pairs of eyeglasses shall be special authorized as medically indicated through the Early Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

2. Changes in prescription shall meet a minimum of:

±0.50 sphere
±0.50 cylinder
1.00 cylinder or less--10° change in axis
1.25 cylinder or greater--5° change in axis

3. Telephone contacts shall be excluded from payment by Kentucky Medicaid.

4. Contact lenses shall be excluded from Kentucky Medicaid payment and shall not be substituted as eyeglasses. Procedure code 92070 shall be used to bill for the therapeutic bandage lens used in the treatment of diseases, (e.g., bullous keratopathy, or non-healing corneal ulcers). The fitting of contact lenses shall be payable **ONLY** when any one (1) of the following criteria is met:

   (a) The CORRECTED acuity in the recipient's best eye is 20/50 and shall be improved with use of contact lenses;

   (b) The visual prescription of ±8.00 diopter or greater;

   (c) The recipient diagnosis is 4.00 diopter anisometropia (difference in power between eyes); or

   (d) The words MEDICALLY INDICATED OR MEDICALLY NECESSARY shall be written or typed on the claim form. If this is not done, the provider must attach to the claim form a written or typed note or a formal attachment (e.g., the invoice or recipient medical record) stating that this method of correction is MEDICALLY INDICATED OR MEDICALLY NECESSARY. Documentation in the recipient's medical record shall substantiate why this method of correction was medically necessary or medically indicated.

5. Tint shall be payable by Kentucky Medicaid **ONLY** if the prescription specifically states the diagnosis of photophobia. This diagnosis shall be entered on the billing form. Include the tint cost within the cost of the lenses. This policy shall be subject to enforcement by postpayment review of claims.

6. Kentucky Medicaid Program reimbursement for eyeglasses shall be considered payment in full. The cost of both laboratory materials and dispensing fees may be billed to either the program or the recipient. If any portion of this fee billed to the recipient is paid by the recipient, Kentucky Medicaid shall not assume responsibility for payment of the same service and a claim shall not be submitted to Kentucky Medicaid

for additional payment. A claim for the same service may, however, be submitted to Kentucky Medicaid for payment if the provider refunds the amount paid by the recipient for the Kentucky Medicaid Program covered service **before** billing the program.

7. Safety glasses shall be payable **only** when medically indicated or medically necessary. The rationale for prescribing safety glasses shall be reported on the claim form, (e.g., recipient is blind in one (1) eye or has only one (1) eye); therefore, he requires additional protection for the remaining eye.

8. Press-on prism(s) shall be excluded from Kentucky Medicaid payment.

9. The cost of prism(s) when medically necessary shall be included within the cost of the lenses.

10. Low-Vision Services shall be excluded from Kentucky Medicaid payment.

E. Dispensing of Eyeglasses

The dispensing of eyeglasses shall include:

- Single vision prescriptions
- Bifocal (no trifocal) vision prescriptions
- Services to frames
- Delivery of completed prescription

1. SINGLE VISION PRESCRIPTIONS – The lens selection and design shall meet the recipient's physical, occupational, and recreational needs and requirements. The prescriber shall verify that the finished prescription lens power is correct as ordered and that lens specifications have been met. The prescriber shall be responsible for ascertaining that only first-quality eyeglass materials approved by the Kentucky Medicaid Program have been

provided for the Kentucky Medicaid Program recipients, and that the fabrication conforms to the standards.

THE PRESCRIBER SHALL BE RESPONSIBLE AT NO ADDITIONAL COST TO THE KENTUCKY MEDICAID PROGRAM OR THE RECIPIENT, FOR THE REPLACEMENT OF INACCURATELY FILLED PRESCRIPTIONS, NON-AUTHORIZED MATERIALS, DEFECTIVE MATERIALS, OR IMPROPERLY FITTING LENSES.

2. BIFOCAL PRESCRIPTIONS - Bifocal prescriptions shall have the same requirements as single vision prescriptions except when contraindicated.

3. SERVICES TO FRAMES. Services to frames shall include selecting frames, measuring the recipient's face for fitting, and fulfilling the recipient's occupational and recreational requirements. The provider shall allow the recipient to try on and select from an adequate number of appropriate, approved frame styles. The minimum number of frames for selection shall be three (3) girl's frame styles and three (3) boy's frame styles. Three (3) frame sizes of each style shall be available for selection by the recipient. The recipient shall be permitted to use his frame if he chooses. The provider shall verify that the finished prescriptions meet the frame specifications ordered and that only first-quality materials, approved by Kentucky Medicaid, have been provided for recipients. **THE PROVIDER SHALL BE RESPONSIBLE AT NO ADDITIONAL COST TO THE KENTUCKY MEDICAID PROGRAM OR THE RECIPIENT, FOR INACCURATELY FILLED PRESCRIPTIONS, NON-AUTHORIZED MATERIALS, DEFECTIVE MATERIALS, OR IMPROPERLY FITTING FRAMES.**

4. DELIVERY OF COMPLETED VISION PRESCRIPTION - Delivery of the completed prescription shall include instruction of the recipient in the use of the prescription, any adjustment of the prescription, and any subsequent minor adjustments for a period of one (1) year. These services shall be performed by the provider at no additional cost to the Kentucky Medicaid Program or the recipient.

F. Professional Services for Dispensing and Repairing Eyeglasses

Procedure codes for dispensing and repairing eyeglasses are contained in the American Medical Association **Physicians' Current Procedural Terminology (CPT) Book.** Codes from this source that are reimbursable by Kentucky Medicaid shall include 92340, 92341, 92352, 92353, and 92370.

Optometrists and opticians shall report their usual and customary charges for professional dispensing procedures when submitting claims to Kentucky Medicaid. Reimbursement shall be provided by Kentucky Medicaid **only** for recipients under twenty-one (21) years of age.

G. Eyeglass Procedure Codes

The following laboratory procedure codes and descriptions for eyeglasses and eyeglass parts shall be reimbursable by the Kentucky Medicaid Program and used when submitting claims for reimbursement.

CODE	PROCEDURE DESCRIPTION
V2020	Frames, Purchases
V2100	Sphere, Single Vision, Plano to Plus or Minus, 4.00, Per Lens
V2101	Sphere, Single Vision, Plus or Minus 4.12 to Plus or Minus 7.00D, Per Lens
V2102	Sphere, Single Vision, Plus or Minus 7.12 to Plus or Minus 20.00D, Per Lens
V2103	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2104	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2105	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2106	Spherocylinder, Single Vision, Plano to Plus or Minus 4.00D Sphere, Over 6.00D Cylinder, Per Lens

V2107	Spherocylinder, Single Vision, Plus or Minus 4.25 to Plus or Minus 7.00 Sphere, .12 to 2.00D Cylinder, Per Lens
V2108	Spherocylinder, Single Vision, Plus or Minus 4.25D to Plus or Minus 7.00 Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2109	Spherocylinder, Single Vision, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2110	Spherocylinder, Single Vision, Plus or Minus 4.25 to 7.00D Sphere, Over 6.00D Cylinder, Per Lens
V2111	Spherocylinder, Single Vision, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, .25 to 2.25 Cylinder, Per Lens
V2112	Spherocylinder, Single Vision, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 2.25D to 4.00D Cylinder, Per Lens
V2113	Spherocylinder, Single Vision, Plus or Minus 7.25 to Plus or Minus 2.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2114	Spherocylinder, Single Vision, Sphere Over Plus or Minus 12.00D, Per Lens
V2115	Lenticular, (Myodisc), Per Lens, Single Vision
V2116	Lenticular Lens, Nonaspheric, Per Lens, Single Vision
V2117	Lenticular, Aspheric, Per Lens, Single Vision
V2118	Aniseikonic Lens, Single Vision
V2199	Not Otherwise Classified, Single Vision Lens Bifocal, Glass or Plastic (Up to and Including 28mm Seg Width, Add Power Up to and Including 3.25D)
V2200	Sphere, Bifocal, Plano to Plus or Minus, 4.00D, Per Lens
V2201	Sphere, Bifocal, Plus or Minus 4.12 to Plus or Minus 7.00D, Per Lens
V2202	Sphere, Bifocal, Plus or Minus 7.12 to Plus or Minus 20.00D, Per Lens
V2203	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2204	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2205	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2206	Spherocylinder, Bifocal, Plano to Plus or Minus 4.00D Sphere, Over 6.00D Cylinder, Per Lens

V2207	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, .12 to 2.00D Cylinder, Per Lens
V2208	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 2.12 to 4.00D Cylinder, Per Lens
V2209	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2210	Spherocylinder, Bifocal, Plus or Minus 4.25 to Plus or Minus 7.00D Sphere, Over 6.00D Cylinder, Per Lens
V2211	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 25 to 2.25D Cylinder, Per Lens
V2212	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 2.25 to 4.00D Cylinder, Per Lens
V2213	Spherocylinder, Bifocal, Plus or Minus 7.25 to Plus or Minus 12.00D Sphere, 4.25 to 6.00D Cylinder, Per Lens
V2214	Spherocylinder, Bifocal, Sphere Over Plus or Minus 12.00D, Per Lens
V2215	Lenticular, (Myodisc), Per Lens, Bifocal
V2216	Lenticular, Nonaspheric, Per Lens, Bifocal
V2217	Lenticular, Aspheric Lens, Bifocal
V2218	Aniseikonic, Per Lens, Bifocal
V2219	Bifocal Seg Width Over 28mm
V2220	Bifocal Add Over 3.25D
V2299	Specialty Bifocal
V2410	Variable Sphericity Lens, Single Vision, Full Field, Glass or Plastic, Per Lens
V2430	Variable Sphericity Lens, Bifocal, Full Field, Glass or Plastic, Per Lens
V2499	Not Otherwise Classified, Variable Sphericity Lens
W0091	Hinge Repair
W0092	Two Temples Only
W0093	One Temple Only
W0094	Front Only

If a provider does his own laboratory work, the vision laboratory invoice may be his own letterhead paper with the breakdown of the lens cost (i.e., labor cost of materials, edging, hardening, coating, etc.). A copy shall be maintained in the recipient's medical records.

If a frame or frame part is supplied from the provider's own stock, the frame name and its manufacturer shall be entered under the procedure description on the claim form or on the letterhead invoice.

If vision supplies are ordered from the manufacturer, the provider shall ascertain the manufacturer's invoice. The invoice shall be maintained in the recipient's medical records.

NOTE: Claims submitted for the above referenced covered eyeglasses and eyeglass materials shall reflect the actual laboratory cost of the materials. The prescription and actual laboratory costs of eyeglass materials shall be maintained in recipient medical records. Reimbursement for eyeglasses and eyeglass parts shall be provided by Kentucky Medicaid **ONLY** for recipients under twenty-one (21) years of age.

H. Provider - Patient Contacts

Pursuant to 907 KAR 1:009 Section I, the Kentucky Medicaid Program shall provide reimbursement to a physician for service(s) provided for a recipient **ONLY** when there is actual physician-patient contact except as provided for herein. The provider shall bill Kentucky Medicaid only for services actually performed. Charges shall not be submitted for recipients who visit the office when the provider does not actually see and examine, treat or diagnose the recipient. Additionally, charges shall not be submitted to Kentucky Medicaid when services are performed or recipient contacts are made **exclusively** by assistants to the provider, employees, nurses, etc.

Telephone contacts with the recipients shall **not** be recognized or payable as visits. Therefore, the Program shall not be billed for a visit when telephone contact is the only service provided. Similarly, contacts between providers, or provider employees, and the recipients for the sole purpose of obtaining a prescription or prescription refills shall not be considered visits and the Program shall not be billed. Covered services provided by **licensed** medical professionals under the direct, personal supervision of a participating Kentucky Medicaid provider shall be billed to the Kentucky Medicaid Program **only** when the **licensed** professional is

employed on a continuing basis by the Kentucky Medicaid participating provider. The Kentucky Medicaid provider under whose number the claim is submitted shall have provider-patient contact at some point during each treatment session billed. The professional shall be licensed in the state where he actively practices and the services provided shall be within the scope of that license.

The Kentucky Medicaid provider may not serve merely as a billing agent for a licensed medical professional or any agency that cannot otherwise be paid by the Kentucky Medicaid Program.

I. Consultation Services

Requests for consultation services from the attending provider and the need for consultation shall be documented in the recipient's medical record. The consultant's assessment, opinion, and any services ordered or performed shall also be documented in the recipient's medical record. This information shall be communicated **in writing** to the referring provider.

After an initial consultation in the consultant's office or other outpatient facility, follow-up visits **initiated by the consultant** shall be reported using office visit codes for established patients.

Initial inpatient consultations shall be limited to **ONE (1)** initial consultation per consultant provider, per recipient, per hospitalization.

If a consultant assumes responsibility for management of a portion or all of a recipient's healthcare, consultation codes shall not be used. In the hospital inpatient setting, the provider receiving the recipient for partial or complete transfer of care shall use the appropriate subsequent hospital care codes. In the office setting, the appropriate established patient codes shall be used.

The application of this policy shall be subject to enforcement by the postpayment review of claims.

REIMBURSEMENT

SECTION V

SECTION V - REIMBURSEMENT

A. Optometrists

Reimbursement of optometrists shall be in accordance with 907 KAR 1:631.

B. Opthalmic Dispensers

Reimbursement for opthalmic dispensers shall be in accordance with 907 KAR 1:631.

C. Laboratory Services

Providers who bill for clinical laboratory codes must comply with the requirements set forth in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). A copy of the CLIA certification must be sent to the Department for Medicaid Services, so that the CLIA number can be placed on the provider's file. Reimbursement for clinical laboratory services shall be based on the lesser of the providers usual and customary billed charges, or Medicare allowable payment rates. For laboratory codes which have no Medicare allowable fee on file, reimbursement shall be based on sixty-five (65) percent of the usual and customary actual billed charges.

D. Reimbursement in Relation to Medicare

1. Deductible and Coinsurance

Medicaid Program recipients who are **also eligible** for benefits under Title XVIII-Parts A and B (Medicare Hospital Insurance and Supplementary Medical Insurance) shall be required to utilize their benefits under Title XVIII (Medicare) prior to the availability of benefits under the Medicaid (Title XIX) Program. Title XVIII accepts primary liability for all payment sought.

- Deductibles are those medical expenses which the recipient shall initially pay on an annual basis to qualify for subsequent Medicare reimbursement. Coinsurance is a cost-sharing requirement which provides that a recipient shall assume a portion or percentage of the costs of covered services. Medicaid shall pay the Medicare deductible and coinsurance amounts for all Medicare covered services submitted on cross-over claims for eligible recipients.

The Medicaid Program shall make payments on behalf of those Title XIX recipients who are **also entitled** to benefits under Medicare Title XVIII-Part A of Public Law 89-97. The Medicaid Program shall pay the deductible and coinsurance amounts as determined by Medicare.

2. Qualified Medicare Beneficiary

Effective February 1, 1989, Section 301 of the Medicare Catastrophic Coverage Act of 1988 requires states to provide Medicaid coverage to certain Medicare beneficiaries in order to pay Medicare cost-sharing expenses (premium, deductible coinsurance amounts). Individuals entitled to Medicare Part A and who do not exceed federally-established income and resource standards may be eligible to receive Medicaid benefits as Qualified Medicare Beneficiaries (QMB's). These individuals receive unique, tricolored (red, white, blue) identification cards. Reimbursable services for QMB recipients shall be limited to coinsurance and deductibles for all Medicare (Parts A and B) covered services or items regardless of whether the services or items are routinely covered by Kentucky Medicaid.

3. Dual Eligibility for QMB and Medicaid

The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) further provides that specified individual meeting income and resource standards for QMB and also meeting Medicaid eligibility criteria shall have dual eligibility for OMB benefits and Medicaid benefits. These individuals

receive a regular white Medical Assistance Identification card with QMB printed on the front, upper right portion of the card.

NOTE: On April 1, 1990, OBRA legislation mandated that assignment be accepted on all Medicare/Medicaid claims. This includes Qualified Medicare Beneficiary (QMB) claims. Unassigned claims submitted for coinsurance and deductible payments shall be denied for medical services provided on or after this April 1, 1990, date.

The Medicaid Program shall make payment for all Medicare deductible and coinsurance amounts for the time period any recipient is QMB or dually eligible.

E. Fees - Duplicate or Inappropriate

Effective July 1, 1994, the Kentucky Medicaid Program implemented a comprehensive, computerized auditing system for provider claims submitted for payment. The auditing system was designed to evaluate billing information and coding accuracy on claims submitted for payment to prevent duplicate or inappropriate payment. Based on coding criteria and protocols in the Physician's Current Procedural Terminology (CPT) code book introduced and published annually by the American Medical Association, this automated system of checking claims shall be utilized to detect miscoding and irregularities, i.e., unbundling which involves billing two (2) or more individual CPT codes that may be combined under a single code and charge, mutually exclusive procedures, incidental or integral procedures, etc. The logic of this oversight system shall supersede any Kentucky Medicaid audits or edits previously implemented. As complex developments in medical technology are introduced and require more specific coding, this automated, claim checking system shall be updated to assist in the processing and payment of claims for Kentucky Medicaid providers in a way more consistent with CPT and International Classification of Diseases (ICD-9) criteria.

Any duplicate or inappropriate payments issued by Kentucky Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Kentucky Medicaid. Refund checks shall be made payable to "Kentucky State Treasurer" and sent to the fiscal agent.

Failure to refund a duplicate or inappropriate payment shall be interpreted as fraud or abuse, and therefore, subject to prosecution.

F. Fee Payment By Recipient

Participants in the program shall report **ALL** payments or deposits made toward a recipient's account, regardless of the source of payment. If the provider receives payment from an eligible Medicaid Program recipient for a Medicaid covered service, the Medicaid Program regulations preclude payment being made by the program for that service unless documentation is received that the payment has been refunded to the recipient. This policy shall not apply to payments made by recipients for spenddown or non-covered services.

Recipients approved for Medicaid benefits on a spend down basis shall be obligated to pay fees to health care providers as assigned by their local Department for Social Insurance where eligibility is established. These fees shall be paid to the providers by the recipients and shall satisfy the excess income for the period of eligibility. These fee payments by the recipients shall be reported by the providers on the claim form as payments from other sources.

Any item(s) or service(s) provided for Medicaid recipients non-covered by Kentucky Medicaid may be billed to the recipient or any other responsible party. Providers shall not collect fees from recipients for covered item(s) or service(s) for which Kentucky Medicaid shall be accepted by the provider as payment in full for a service.

SECTION V - REIMBURSEMENT

If a recipient has retroactive eligibility in which the individual receives a back-dated Medicaid card, the provider of service shall maintain the option to accept the Kentucky Medicaid card. If the provider agrees to accept the card, any payments made to the provider by the recipient for services during the retroactive eligible period will require a 100 percent refund to the recipient before the program may be billed.

VISION PROGRAM MANUAL

APPENDIX

TRANSMITTAL #20
02/97

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

Following is a listing of the most frequently used diagnosis codes for vision care:

V53.1 Fitting and adjusting spectacles and contact lenses
V66.9 Follow-up Call (Convalescence - No diagnosis but referred back)
V68.1 Repair and adjusting spectacles
V72.0 Examination of eyes and vision
V80.2 Frame for Cataracts (Other eye conditions, screening for)

DIAGNOSIS CODE	DIAGNOSIS
360.4	Degenerated conditions of globe
360.40	Degenerated globe or eye, unspecified
360.41	Blind hypotensive eye
360.42	Blind hypertensive eye
360.43	Hemophthalmos, except current injury Excludes: traumatic (871.0-871.9, 921.0-921.9)
360.5	Retained (old) intraocular foreign body, magnetic Excludes: current penetrating injury with magnetic foreign body (871.5) retained (old) foreign body of orbit (376.6)
360.50	Foreign body, magnetic, intraocular, unspecified
360.51	Foreign body, magnetic, in anterior chamber
360.52	Foreign body, magnetic, in iris or ciliary body
360.53	Foreign body, magnetic, in lens
360.54	Foreign body, magnetic, in vitreous
360.55	Foreign body, magnetic, in posterior wall
360.59	Foreign body, magnetic, in other or multiple sites
360.6	Retained (old) intraocular foreign body, nonmagnetic Retained (old) foreign body:

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

NOS -
nonmagnetic
Excludes: current penetrating injury with
(nonmagnetic) foreign body (871.6)
retained (old) foreign body in orbit (376.6)

360.60	Foreign body, intraocular, unspecified
360.61	Foreign body in anterior chamber
360.62	Foreign body in iris or ciliary body
360.63	Foreign body in lens
360.64	Foreign body in vitreous
360.65	Foreign body in posterior wall
360.69	Foreign body in other or multiple sites

365	Glaucoma

Excludes: blind hypertensive eye (absolute glaucoma) (360.42)
congenital glaucoma (743.20-743.22)

365.0	Borderline glaucoma (glaucoma suspect)
365.00	Preglaucoma, unspecified
365.01	Open angle with borderline findings
365.02	Anatomical narrow angle
365.03	Steroid responders
365.04	Ocular hyptertension
365.59	Glaucoma associated with other lens disorders
365.6	Glaucoma associated with other ocular disorders
365.60	Glaucoma associated with unspecified ocular disorder
365.61	Glaucoma associated with pupillary block
365.62	Glaucoma associated with ocular inflammations
365.63	Glaucoma associated with vascular disorders
365.64	Glaucoma associated with tumors or cysts

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

365.65	Glaucoma associated with ocular trauma
365.8	Other specified forms of glaucoma
365.81	Hypersecretion glaucoma
365.82	Glaucoma with increased episcleral venous pressure
365.89	Other specified glaucoma
365.9	Unspecified glaucoma
366	Cataract Excludes: congenital cataract (743.30-743.34)
366.0	Infantile, juvenile, and presenile cataract
366.00	Nonsenile cataract, unspecified
366.01	Anterior subcapsular polar cataract
366.02	Posterior subcapsular polar cataract
366.03	Cortical, lamellar, or zonular cataract
366.04	Nuclear cataract
366.09	Other and combined forms of nonsenile cataract
366.1	Senile cataract
366.10	Senile cataract, unspecified
366.11	Pseudoexfolition of lens capsule
366.12	Incipient cataract
366.13	Anterior subcapsular polar senile cataract
366.14	Posterior subcapsular polar senile cataract
366.15	Cortical senile cataract
366.16	Nuclear sclerosis
366.17	Total or mature cataract
366.18	Hypermature cataract
366.19	Other and combined forms of senile cataract

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

366.2 Traumatic cataract

- 366.20 Traumatic cataract, unspecified
- 366.21 Localized traumatic opacities
- 366.22 Total traumatic cataract
- 366.23 Partially resolved traumatic cataract

366.3 Cataract secondary to ocular disorders

- 366.30 Cataracts complicata, unspecified
- 366.31 Glaucomatous flecks (subcapsular)
- 366.32 Cataract in inflammatory disorders
- 366.33 Cataract with neovascularization
- 366.34 Cataract in degenerative disorders

366.4 Cataract associated with other disorders

- 366.41 Diabetic cataract
- 366.42 Tetanic cataract
- 366.43 Myotonic cataract
- 366.44 Cataract associated with other syndromes
- 366.45 Toxic cataract
- 366.46 Cataract associated with radiation and other physical influences

366.5 After-cataract

- 366.50 After-cataract, unspecified
- 366.51 Soemmering's ring
- 366.52 Other after-cataract, not obscuring vision
- 366.53 After-cataract, obscuring vision

366.8 Other cataract

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

366.9	Unspecified cataract
367	Disorders of refraction and accommodation
367.0	Hypermetropia
367.1	Myopia
367.2	Astigmatism
367.3	Anisometropia and aniseikonia
367.31	Anisometropia
367.32	Aniseikonia
367.4	Presbyopia
367.5	Disorders of accommodation
367.51	Paresis of accommodation
367.52	Total or complete internal ophthalmoplegia
367.53	Spasm of accommodation
367.8	Other disorders of refraction and accommodation
367.81	Transient refractive change
367.89	Other
367.9	Unspecified disorder of refraction and accommodation
368	Visual disturbances

Excludes: electrophysiological disturbances (794.11-794.14)

368.0	Amblyopia ex anopsia
368.00	Amblyopia, unspecified

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

368.01	Strabismic amblyopia
368.02	Deprivation amblyopia
368.03	Refractive amblyopia
368.1	Subjective visual disturbance
368.10	Subjective visual disturbance, unspecified
368.11	Sudden visual loss
368.12	Transient visual loss
368.13	Visual discomfort - photophobia
368.14	Visual distortions of shape and size
368.15	Other visual distortions and entoptic phenomena
368.2	Diplopia
368.3	Other disorders of binocular vision
368.30	Binocular vision disorder, unspecified
368.31	Suppression of binocular vision
368.32	Simultaneous visual perception without fusion
368.33	Fusion with defective stereopsis
368.34	Abnormal retinal correspondence
368.4	Visual field defects
368.40	Visual field defect, unspecified
368.41	Scotoma involving central area
368.42	Scotoma of blind spot area
368.43	Section or arcuate defects
368.44	Other localized visual field defect
368.45	Generalized contraction or constriction
368.46	Homonymous bilateral field defects
368.47	Heteronymous bilateral field defects

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

368.6	Night blindness
368.60	Night blindness, unspecified
368.61	Congenital night blindness
368.62	Acquired night blindness
Excludes:	that due to vitamin A deficiency (264.5)
368.63	Abnormal dark adaptation curve
368.69	Other night blindness
368.8	Other specified visual disturbances
368.9	Unspecified visual disturbance
369	Blindness and low vision
369.0	Profound impairment, both eyes
369.00	Impairment level not further specified
369.01	Better eye: total impairment lesser eye: total impairment
369.02	Better eye: near-total impairment lesser eye: not further specified
369.03	Better eye: near-total impairment lesser eye: total impairment
369.04	Better eye: near-total impairment lesser eye: near-total impairment
369.05	Better eye: profound impairment lesser eye: not further specified
369.06	Better eye: profound impairment lesser eye: total impairment
369.07	Better eye: profound impairment lesser eye: near-total impairment
369.08	Better eye: profound impairment lesser eye: profound impairment

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

369.1	Moderate or severe impairment, better eye, profound impairment lesser eye
369.10	Impairment level not further specified
369.11	Better eye: severe impairment; lesser eye: blind, not further specified
369.12	Better eye: severe impairment; lesser eye: total impairment
369.13	Better eye: severe impairment; lesser eye: near-total impairment
369.14	Better eye: severe impairment, lesser eye: profound impairment
369.15	Better eye: moderate impairment; lesser eye: blind, not further specified
369.16	Better eye: moderate impairment; lesser eye: total impairment
369.17	Better eye: moderate impairment; lesser eye: near-total impairment
369.18	Better eye: moderate impairment lesser eye: profound impairment
369.2	Moderate or severe impairment, both eyes
369.20	Impairment level not further specified
369.21	Better eye: severe impairment; lesser eye: not further specified
369.22	Better eye: severe impairment; lesser eye: severe impairment
369.23	Better eye: moderate impairment; lesser eye: not further specified
369.24	Better eye: moderate impairment; lesser eye: severe impairment
369.25	Better eye: moderate impairment;

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

lesser eye: moderate impairment

369.3 Unqualified visual loss, both eyes
Excludes: blindness, NOS:
legal [U.S.A. definition](369.4)
WHO definition (369.00)

369.4 Legal blindness, as defined in U.S.A.
Excludes: legal blindness with specification of impairment level (369.01[0]-369.08,369.11-369.14, 369.21-369.22)

369.6 Profound impairment, one eye

- 369.60 Impairment level not further specified
- 369.61 One eye: total impairment; other eye: not specified
- 369.62 One eye: total impairment; other eye: near-normal vision
- 369.63 One eye: total impairment; other eye: normal vision
- 369.64 One eye: near-total impairment; other eye: not specified
- 369.65 One eye: near-total impairment; other eye: near-normal vision
- 369.66 One eye: near-total impairment; other eye: normal vision
- 369.67 One eye: profound impairment; other eye: not specified
- 369.68 One eye: profound impairment; other eye: near-normal vision
- 369.69 One eye: profound impairment; other eye: normal vision

369.7 Moderate or severe impairment, one eye

- 369.70 Impairment level not further specified
- 369.71 One eye: severe impairment; other eye: not specified
- 369.72 One eye: severe impairment; other eye: near-normal vision
- 369.73 One eye: severe impairment; other eye: normal vision
- 369.74 One eye: moderate impairment; other eye: not specified
- 369.75 One eye: moderate impairment; other eye: near-normal vision
- 369.76 One eye: moderate impairment; other eye: normal vision

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

369.8	Unqualified visual loss, one eye
369.9	Unspecified visual loss
370	Keratitis
370.0	Corneal ulcer Excludes: that due to vitamin A deficiency (264.3)
370.00	Corneal ulcer, specified
370.01	Marginal corneal ulcer
370.02	Ring corneal ulcer
370.03	Central corneal ulcer
370.04	Hypopyon ulcer
370.05	Mycotic corneal ulcer
370.06	Perforated corneal ulcer
370.07	Mooren's ulcer

CLASSIFICATION "legal" WHO	LEVELS OF VISUAL IMPAIRMENT Visual acuity and/or visual field limitation (whichever is worse)	Additional descriptors which shall be encountered
	RANGE OF NORMAL VISION	
(NEAR-) NORMAL VISION	20/10 20/13 20/16 20/20 20/25 2.0 1.6 1.25 1.0 0.8	
	NEAR-NORMAL VISION 20/30 20/40 20/50 20/60 0.7 0.6 0.5 0.4 0.3	

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

MODERATE VISUAL IMPAIRMENT

V 20.70 20/80 20/100 20/125 20/160 Moderate low
L I 0.25 0.20 0.16 0.12 vision
O S
W I **SEVERE VISUAL IMPAIRMENT** Severe low
O 20/200 20/250 20/320 20/400 vision,
B N 0.10 0.08 0.06 0.05 "Legal"
L Visual field: 20 degree or less blindness

L I
E N **PROFOUND VISUAL IMPAIRMENT**
G D B 20/500 20/630 20/800 20/1000 Profound low
A N L 0.04 0.03 0.025 0.02 vision,
L E I Count fingers at; less than 3m Moderate
S N (10 ft.) blindness
S D Visual field: degrees or less
N
E **NEAR-TOTAL VISUAL IMPAIRMENT**
S Visual acuity: less than 0.02 (20/1000 Severe blindness
S

(U.S.A.)
both (WHO) Count fingers at: 1m (3 ft.) or less
eyes Hand movements: 5m (15ft.) or less Near-total
one or Light project, light perception blindness
both Visual field: 5 degrees or less
TOTAL VISUAL IMPAIRMENT Total
No light perception (NLP) blindness

Visual acuity refers to best achievable acuity with correction
Non-listed Snellen fractions may be classified by converting to the nearest decimal equivalent, e.g., 10/200 = 0.05, 6/30 = 0.20
CF (count fingers) without designation of distance, may be classified to profound impairment
HM (hand motion) without designation of distance, may be classified to near-total impairment

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

Visual field measurements refer to the largest field diameter for a 1/100 white test object

371.2	Corneal edema
371.20	Corneal edema, unspecified
371.21	Idiopathic corneal edema
371.22	Secondary corneal edema
371.23	Bullous keratopathy
372.24	Corneal edema due to wearing of contact lenses
372.0	Acute conjunctivitis
372.00	Acute conjunctivitis, unspecified
372.1	Chronic conjunctivitis
372.10	Chronic conjunctivitis, unspecified
372.11	Simple chronic conjunctivitis
372.14	Other chronic allergic conjunctivitis
377.1	Optic atrophy
371.10	Optic atrophy, unspecified
371.11	Primary optic atrophy Excludes: neurosyphilitic optic atrophy (094.84)
377.12	Postinflammatory optic atrophy
377.13	Optic atrophy associated with retinal dystrophies
377.14	Glaucomatous atrophy (cupping) of optic disc
377.15	Partial optic atrophy
377.16	Hereditary optic atrophy
378	Strabismus and other disorders of binocular eye movements Excludes: nystagmus and other irregular eye movements (379.50-379.59)

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

378.00	Esotropia, unspecified
378.01	Monocular esotropia
378.02	Monocular esotropia with A pattern
378.03	Monocular esotropia with V pattern
378.04	Monocular esotropia with other noncomitancies
378.05	Alternating esotropia
378.06	Alternating esotropia with A pattern
378.07	Alternating esotropia with V pattern
378.08	Alternating esotropia with other noncomitancies
378.1	Esotropia Excludes: intermittent exotropia (378.20, 378.23-378.24)
378.10	Exotropia, unspecified
378.11	Monocular exotropia
378.12	Monocular exotropia with A pattern
378.13	Monocular exotropia with V pattern
378.14	Monocular exotropia with other noncomitancies
378.15	Alternating exotropia
378.16	Alternating exotropia with A pattern
378.17	Alternating exotropia with V pattern
378.18	Alternating exotropia with other noncomitancies
378.2	Intermittent heterotropia Excludes: vertical heterotropia (intermittent) (378.31)
378.20	Intermittent heterotropia, unspecified
378.21	Intermittent esotropia, monocular
378.22	Intermittent exotropia, alternating
378.23	Intermittent exotropia, monocular
378.24	Intermittent exotropia, alternating
378.3	Other and unspecified heterotropia

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

378.31	Hypertropia
378.32	Hypotropia
378.33	Cyclotropia
378.34	Monfixation syndrome
378.35	Accommodative component in esotropia
378.4	Heterophoria
378.40	Heterophoria, unspecified
378.41	Esophoria
378.42	Exophoria
378.43	Vertical heterophoria
378.44	Cyclophoria
378.45	Alternating hyperphoria
378.5	Paralytic strabismus
378.50	Paralytic strabismus, unspecified
378.51	Third or oculomotor nerve palsy, partial
378.52	Third or oculomotor nerve palsy, total
378.53	Fourth or trochlear nerve palsy
378.54	Sixth or abducens nerve palsy
378.55	External ophthalmoplegia
378.56	Total ophthalmoplegia
378.6	Mechanical strabismus
378.60	Mechanical strabismus, unspecified
378.61	Brown's (tendon) sheath syndrome
378.62	Mechanical strabismus from other musculofascial disorders
378.63	Limited duction associated with other conditions
378.7	Other specified strabismus

CABINET FOR HEALTH SERVICES
DEPARTMENT FOR MEDICAID SERVICES

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

378.71	Duane's syndrome
378.72	Progressive external ophthalmoplegia
378.73	Strabismus in other neuromuscular disorders
378.8	Other disorders of binocular eye movements Excludes: nystagmus (379.50-379.56)
378.81	Palsy of conjugate gaze
378.82	Spasm of conjugate gaze
378.83	Convergence insufficiency or palsy
378.84	Convergence excess or spasm
378.85	Anomalies of divergence
378.86	Internuclear ophthalmoplegia
378.87	Other dissociated deviation of eye movements
378.9	Unspecified disorder of eye movements
379.3	Aphakia and other disorders of lens Excludes: after-cataract (366.50-366.53)
379.31	Aphakia
379.32	Subluxation of lens
379.33	Anterior dislocation of lens
379.34	Posterior dislocation of lens
379.39	Other disorders of lens
379.4	Anomalies of pupillary function
379.42	Miosis (persistent), not due to miotics
379.43	Mydriasis (persistent), not due to miotics
379.45	Argyll Robertson pupil, atypical Excludes: Argyll Robertson pupil (Syphilitic) (094.89)

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

379.46	Tonic pupillary reaction -
379.49	Other
379.5	Nystagmus and other irregular eye movements
379.50	Nystagmus, unspecified
379.51	Congenital nystagmus
379.52	Latent nystagmus
379.53	Visual deprivation nystagmus
379.54	Nystagmus associated with disorders of the vestibular system
379.55	Dissociated nystagmus
379.56	Other forms of nystagmus
379.57	Deficiencies of saccadic eye movements
379.58	Deficiencies of smooth pursuit movements
379.59	Other irregularities of eye movements
379.8	Other specified disorders of eye and adnexa
379.9	Unspecified disorder of eye and adnexa
379.90	Disorder of eye, unspecified
379.91	Pain in or around eye
379.92	Swelling or mass of eye
379.93	Redness or discharge of eye
379.99	Other ill-defined disorders of eye Excludes: blurred vision NOS (368.9)
743.3	Congenital cataract and lens anomalies Excludes: infantile cataract (366.00-366.09)
743.30	Congenital cataract, unspecified
743.31	Capsular and subcapsular cataract
743.32	Nuclear cataract
743.34	Total and subtotal cataract, congenital

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

743.35 Congenital aphakia
743.36 Anomalies of lens shape
743.37 Congenital ectopic lens
743.39 Other

743.4 Coloboma and other anomalies of anterior segment

743.41 Anomalies of corneal size and shape
Excludes: that associated with buphthalmos (743.22)
743.42 Corneal opacities, interfering with vision, congenital
743.43 Other corneal opacities, congenital
743.44 Specified anomalies of anterior chamber, chamber angle, and related structures
743.45 Aniridia
743.46 Other specified anomalies of iris and ciliary body
743.47 Specified anomalies of sclera
743.48 Multiple and combined anomalies of anterior segment
743.49 Other

871 Open wound of eyeball
Excludes: 2nd cranial nerve injury (950.0-950.9)
3rd cranial nerve injury (951.0)

871.0 Ocular laceration without prolapse of intraocular tissue
871.1 Ocular laceration with prolapse of intraocular tissue
871.2 Rupture of eye with partial loss of intraocular tissue
871.3 Avulsion of eye
871.4 Unspecified laceration of eye
871.5 Penetration of eyeball with magnetic foreign body
Excludes: retained (old) magnetic foreign body in globe (360.50-360.59)
871.6 Penetration of eyeball with (nonmagnetic) foreign body
Excludes: retained (old) (nonmagnetic) foreign body in globe (360.60-360.69)

DIAGNOSIS CODES FREQUENTLY USED FOR VISION CARE

871.7	Unspecified ocular penetration
871.9	Unspecified open wound of eyeball